STATE OF MAINE

NURSING HOME ADMINISTRATORS LICENSING BOARD

APPLICATION FOR LICENSURE

- Administrator-In-Training Program
- Temporary Nursing Home Administrator
- Nursing Home Administrator
- Multi-Level Long Term Care Facility Administrator

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY/HEARING IMPAIRED (888) 577-6690
Email: jennifer.l.mooney@maine.gov

Office located at: 122 Northern Avenue, Gardiner, Maine 04345

Revised 2006

Application Guide

Please read all the information carefully. If you have any questions, you can contact the Nursing Home Administrators Licensing Board office at (207) 624-8626 or email jennifer.l.mooney@maine.gov

Furnished to Applicant:

1. Application Guide
2. Application for Licensure
3. Application for State Examination
4. Verification of Licensure Form
5. Statement of Need
6. Accommodation Request Form
7. Authorization of Credit Card Payment Form

GENERAL INFORMATION:

All material pertaining to an application must be received by the Board within a span of no more than six months. Applications which remain incomplete for more than six months will be disposed of. Candidates whose applications have been incomplete for more than six months will be required to submit **new** application materials if they seek licensure.

All name and/or address changes must be submitted to the Board, **in writing**, either by mail or fax throughout your licensure.

ADMINISTRATOR-IN-TRAINING PROGRAM (AIT)

All applicants applying for an Administrator-in-Training Program (AIT) must submit the following:

- ☐ Completed and signed application for licensure;
- ☐ **Fees:** All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;
  - **$75.00** Application Fee
  - **$75.00** Examination Fee
  - **$125.00** AIT Fee
  - **$15.00** Criminal History Records Check Fee
- ☐ Transcript(s) documenting educational requirements as stated in Board rules Chapter 2, § 1(B);
- ☐ Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
- ☐ Resume;
- ☐ Formal Training Guide; and
- ☐ Written documentation that the applicant's Preceptor has completed a Board approved Preceptor Training Program.

A Preceptor as defined in Board Rules shall supervise the AIT program. Please review Chapter 2 of the Board Rules for further information pertaining to application for the AIT Program.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation.

During the AIT program, the applicant shall submit a monthly progress report, which shall provide the Board with a summary of the previous month's activities, including dates and times of the activities. The Preceptor shall review and sign this report, which shall be submitted to the Board by the 10th of the following month.

Upon completion of the AIT Program and all other necessary requirements, the applicant shall make application for examination in writing on forms provided by the Board. Upon successful completion of both the state and national examinations, the applicant shall be eligible for licensure.

NURSING HOME ADMINISTRATOR

All applicants applying for licensure as a Nursing Home Administrator must have passed both the state and national examinations and must submit the following requirements:

☐ Completed and signed application for licensure;

☐ **Fees:** All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;

- **$75.00** Application Fee
- **$75.00** Examination Fee
- **$200.00** License Fee
- **$15.00** Criminal History Records Check Fee

☐ Transcript(s) documenting educational requirements as stated in Board rules Chapter 2, § 1(B);

☐ Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;

☐ Resume; and

☐ Documentation that the applicant has completed a Board–approved AIT Program or be eligible for endorsement as specified in Chapter 6 of the Board Rules.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they shall be scheduled to sit for the state examination. Upon successful completion of the state examination, they shall be issued a license as a Nursing Home Administrator.

TEMPORARY LICENSURE

In order to fill a position that unexpectedly becomes vacant for an Administrator in a facility covered by Board Rules; the Board shall issue a temporary license provided that the applicant has met the requirements as stated in Chapter 7 of the Board Rules.

All applicants applying for temporary licensure must submit the following:

☐ Completed and signed application for licensure;

☐ **Fees:** All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;

- **$75.00** Application Fee
- **$125.00** License Fee
- **$15.00** Criminal History Records Check Fee

☐ Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;

☐ Resume; and

☐ Notarized Statement of Need.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting for the purpose of orientation.

The temporary license shall be issued for a period not to exceed three (3) months, but it may be renewed for an additional three (3) months at the discretion of the Board, upon demonstration of extreme hardship and in the interest of the public protection.

MULTI-LEVEL LONG TERM CARE FACILITY ADMINISTRATOR

All applicants applying for licensure as a Multi-Level Long Term Care Facility Administrator shall be required to meet the qualifications pertaining to both Nursing Home Administrators and to Residential Care Facility Administrators.

Applicants applying for licensure must submit the requirements pertaining to licensure as a Nursing Home Administrator and in addition, submit documentation that the applicant has demonstrated knowledge of residential care/assisted living by completing one of the requirements stated in Chapter 4, § 1 of the Board Rules.

All applicants applying for licensure as a Multi-Level Long Term Care Facility Administrator must have passed both the state and national examinations.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they shall be scheduled to sit for the state examination. Upon successful completion of the state examination, they shall be issued a license as a Multi-Level Long Term Care Facility Administrator.

ENDORSEMENT

The Board may endorse, without written national examination, a valid, permanent license issued by the proper authorities of any other state to a Nursing Home Administrator or Multi-Level Long Term Care Facility Administrator, upon payment of the established fee, provided that the applicant has met the requirements as stated in Chapter 6, §1 of the Board Rules.

All applicants applying for licensure by endorsement must submit the following:

- ☐ Completed and signed application for licensure;
- ☐ **Fees:** All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;
    - **$75.00** Application Fee
    - **$75.00** Examination Fee
    - **$200.00** License Fee
    - **$15.00** Criminal History Records Check Fee
- ☐ Documentation that the applicant has met the requirement for licensure as stated in Chapter 6 § 1 of Board Rules;
- ☐ Written verification of satisfactory completion of the NAB national examination;
- ☐ Two (2) reference letters indicating the applicant to be of good record and reputation for honest and reliable conduct in personal and business affairs;
- ☐ Resume; and
- ☐ Completed Verification of Licensure from each state in which applicant holds or has held any certification, licensure, or other credential.

Applicants applying for licensure by endorsement must pass the state examination.

Upon submission of the above requirements, the applicant shall report to the Board, at a regularly scheduled meeting, for the purpose of orientation. If an applicant is deemed to have met all requirements, they will be eligible to sit for the state examination. Upon successful completion of the state examination a license will be issued to them for the category in which they are applying.

STATE OF MAINE
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35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
OFFICE PHONE (207) 624-8626
TTY/HEARING IMPAIRED (888) 577-6690

Office Use Only			
License #			
Cash #			
Check #			
4290	1421	$200	AD
4290	1422	$125	AT
4290	1423	$200	MLA
4290	1425	$125	AIT
4290	1446	$75	
4290	2619	$15	

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ Administrator-In-Training Program ☐ Temporary License

☐ Nursing Home Administrator ☐ Multi-Level Long Term Care Administrator

Name: _____

Any other names used: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____

Facility: _____

Mailing Address: _____ County: _____

Work Telephone: (_____) _____

Degree Earned: _____ Date Received: _____

ADMINISTRATOR-IN-TRAINING

Name of Training Site: _____

Address of Training Site: _____

Name of Preceptor: _____

Preceptor's License Number: _____ Date of Licensure: _____

Did Preceptor complete a Preceptor Training Program? ☐ Yes ☐ No Date of completion: _____

Name of Facility where Preceptor is employed: _____

Length of Training Program ☐ Full-time (Six Months) ☐ Part-time (Twelve Months)

Commencement date: _____

Identify additional training sites: SNF: _____

ICF/MR: _____

Residential Care: _____

TEMPORARY LICENSE

Name of Facility: _____

Mailing Address of Facility: _____

Name of License Consultant: _____

Consultant's License Number: _____ Date of Licensure: _____

Name of Facility where Consultant is employed: _____

Mailing Address: _____

Anticipated date of employment as a Temporary Licensee: _____

ENDORSEMENT/RECIPROCITY

Name of state(s) in which you are licensed or have held licenses:

_____ License #: _____

_____ License #: _____

Did you complete a structured Administrator-in-Training Program? ☐ Yes ☐ No

If yes, name of State: _____ Date: _____

Date of original license: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

Have you pled guilty to, pled no contest to, or been found guilty of any crime? ☐ Yes ☐ No
If yes, please provide a copy of the court document record for each crime and a statement of the circumstances surrounding that crime.

Has your license ever been suspended, revoked or subject to any disciplinary action by any state or jurisdiction?
☐ Yes ☐ No **If yes, please attach an explanation.**

Have you ever been excluded from participation in Medicare/Medicaid reimbursement? ☐ Yes ☐ No
If yes, please attach an explanation.

I hereby certify that the above statements are accurate and represent a true statement of fact. By the fact of this application, I waive objection and authorize the Board to make such inquiries, and have access to such information as the Board may consider necessary to determine good character and suitability.

Signature of Applicant **Date**

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Office Use Only			
License #			
Cash #			
Check #			
4290	1447	$75	AD
4290	1447	$75	MLA
4290	1447	$75	AIT

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

APPLICATION FOR STATE EXAMINATION

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

Name: _____

Any other names used: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Facility: _____

Mailing Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Work Telephone: (_____) _____

Completion Date of AIT Program (if applicable): _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

Have you pled guilty to, pled no contest to, or been found guilty of any crime? ☐ Yes ☐ No
If yes, please provide a copy of the court document record for each crime and a statement of the circumstances surrounding that crime.

Has your license ever been suspended, revoked or subject to any disciplinary action by any state or jurisdiction?
☐ Yes ☐ No **If yes, please attach an explanation.**

Have you ever been excluded from participation in Medicare/Medicaid reimbursement? ☐ Yes ☐ No
If yes, please attach an explanation.

I hereby certify that the above statements are accurate and represent a true statement of fact. By the fact of this application, I waive objection and authorize the Board to make such inquiries, and have access to such information as the Board may consider necessary to determine good character and suitability.

_____ _____

Signature of Applicant **Date**

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VERIFICATION OF LICENSURE

The applicant listed below is applying for licensure in the State of Maine. The Maine Nursing Home Administrators Licensing Board requests written verification from each state the applicant holds or has held any certification, licensure, or other credential. This is your authority to release any information in your files, favorable or otherwise. **Please mail this verification directly to the Maine Nursing Home Administrators Licensing Board at the above listed address.**

The section below is to be completed by the applicant and forwarded to the State Board in which you hold or have held certification, licensure, or other credential. Any associated fees are the responsibility of the applicant. If Verification of Licensure is needed for more than one state, please copy form as needed.

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

License Number: _____ State: _____ Date of Issue: _____

_____ _____
Signature of Applicant Date

This section to be completed by the State Licensing Board where the applicant holds or has held any certification, licensure, or other credential.

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____

Education (mark the highest level) ☐ High School ☐ College

☐ Graduate ☐ Post Graduate

Type of License held: _____ License number: _____

State: _____ Date Issued: _____ Expiration Date: _____

(continued on next page)

(continued from previous page)

If this is not the state of original licensure, was license issued through reciprocity/endorsement?

☐ Yes ☐ No From what state? _____

Was this individual licensed on the basis of his/her certification through the American College of Health Care Administrators? ☐ Yes ☐ No

Status of License: ☐ Active ☐ Inactive ☐ Expired

Exam: ☐ NAB ☐ PES ☐ Other

Score Raw _____ Scale _____ Date of Exam: _____ State: _____

Was an AIT/Practicum successfully completed? ☐ Yes ☐ No

If yes, length of AIT/Practicum: _____

Has the Board ever disciplined the applicant? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is there any investigation or disciplinary action pending? ☐ Yes ☐ No

If yes, please explain: _____

_____

Signed _____

Printed name and title _____

State Seal

State _____

Date _____

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DIRECTOR

STATEMENT OF NEED

To be completed for Temporary Licenses only

The position of administrator for _____
Facility

has become unexpectedly vacant due to the following circumstances:

_____

_____

_____

_____

The facility does intend to hire _____
Name

to fill this position with the stipulation that _____
Facility

will retain the following board approved licensed administrator consultant:

_____
Name License Number

during the period in which the applicant renders service to the facility under a temporary license.

_____
Owner or Representative of Governing Board

_____
Date

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4290	1446	$75	
4290	2619	$15	

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GOVERNOR

ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #: (_____)_____-_____***	

Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard** _____
Card number

Expiration date: _____/_____/_____ in the amount of: $_____

Signature: _____ Date: _____/_____/_____

PRINTED ON RECYCLED PAPER

OFFICE PHONE: (207)624-8626 (888) 577-6690 (HEARING IMPAIRED) FAX: (207)624-8637
OFFICES LOCATED AT: 122 NORTHERN AVENUE, GARDINER, MAINE

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JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will note be shared with any outside source without your express written permission.

Name: _____

Address: _____

Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.

Disability _____

Please check all that apply

- ❑ **Accessible Testing Site**
- ❑ **Separate Testing Site**
- ❑ **Braille**
- ❑ **Large Print**
- ❑ **Tape**
- ❑ **Reader as Accommodation for Visual Impairment**
- ❑ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ❑ **Reader as Accommodation for Learning Disability**
- ❑ **Scribe/Amanuensis as Accommodation for Learning**
- ❑ **Sign Language Interpreter**
- ❑ **Extended Time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More than double time (specify)** _____
- ❑ **Use of Computer or Other Adaptive Equipment (specify)** _____
- ❑ **Other:** _____

Signed and Dated: _____

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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a
(Test applicant) (Date)

_____
(Professional title)

The applicant has discussed with me the nature of the test to be administrated. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all types)

- ❑ **Taped test**
- ❑ **Large print test**
- ❑ **Reader**
- ❑ **Scribe/amanuensis**
- ❑ **Extended time**
  - ❑ **Time-and-a-half**
  - ❑ **Double time**
  - ❑ **More that double time (please justify)** _____
- ❑ **Separate Testing Area**
- ❑ **Use of Computer or Other Adaptive Equipment (please specify)** _____
- ❑ **Other (please specify)** _____
  _____

Signed: _____ **Title:** _____

Date: _____ **License # (if applicable):**_____